Note: System of Care Services are voluntary for the family

CT System of Care Uniform Client Record: I. REFERRAL FORM/FACE SHEET

Child/Youth's Name:		
D.O.B.:	Age:	Gender: Male [ ] Female [ ]
Community Collaborative/System of Care:		
Was EMPS # Provided: Yes [ ] No [ ]	Date of Referral:	

Referral Source Name:		Phone Number:	
Referral Source Code (please check a source code below):			
[ ] (1) Danbury DCF	[ ] (14) National Runaway Hotline	[ ] (27) Residential Facility	[ ] (44) Employee Assistance Program
[ ] (2) Torrington DCF	[ ] (15) Crisis Intervention Hotline	[ ] (28) Police	[ ] (45) Juvenile Court, Probation or Parole
[ ] (3) Waterbury DCF	[ ] (16) Child Guidance Clinic	[ ] (29) Hospital	[ ] (46) Family Advocate
[ ] (4) Manchester DCF	[ ] (17) Court/Public Defender/Atty.	[ ] (30) Friend	[ ] (47) Extended Day Treatment
[ ] (5) New Britain DCF	[ ] (18) Youth Service Bureau	[ ] (31) School	[ ] (48) Emergency Psych. Treatment
[ ] (6) Middletown DCF	[ ] (19) Social Service Agency	[ ] (32) Norwalk DCF	[ ] (49) Intensive Family Preservation
[ ] (7) Norwich DCF	[ ] (20) Clergy	[ ] (33) Hartford DCF	[ ] (50) Parent Aide
[ ] (8) Meriden DCF	[ ] (21) Self	[ ] (34) Physician	[ ] (51) Partial Hospitalization
[ ] (9) New Haven DCF	[ ] (22) Parent	[ ] (35) Willimantic DCF	[ ] (52) Dept. of Social Services
[ ] (10) Bridgeport DCF	[ ] (23) Info-Line	[ ] (37) Relative	[ ] (53) Dept. of Mental Retardation
[ ] (11) Stamford DCF	[ ] (24) Foster Family	[ ] (41) Substance Abuse Agency	[ ] (54) Private Provider
[ ] (12) Hotline DCF	[ ] (25) Group Home	[ ] (42) Local Systems of Care	[ ] (62) Emergency Room
[ ] (13) DCF Unspecified	[ ] (26) Temporary Shelter	[ ] (43) Insurance – HMO	[ ] (63) Department of Corrections
			[ ] (99) Other

Hispanic: Yes [ ] No [ ]		
Child's Ethnicity (Please check applicable box):		
[ ] (5) Central American	[ ] (12) Korean	[ ] (20) Mexican
[ ] (6) South American	[ ] (13) Laotian	[ ] (21) Cuban
[ ] (7) Other Spanish Speaking	[ ] (14) Thai	[ ] (22) African American
[ ] (8) West Indies/Islander	[ ] (15) Vietnamese	[ ] (23) Portugese
[ ] (9) Cambodian	[ ] (16) Asian Indian	[ ] (24) Dominican
[ ] (10) Chinese	[ ] (18) Bi-Racial	[ ] (99) Other (Please specify)
[ ] (11) Japanese	[ ] (19) Puerto Rican	
Child's Race (Please check applicable box):		
[ ] (1) White	[ ] (3) Asian American	[ ] (23) Pacific Islander
[ ] (2) Black	[ ] (22) Native American	

Child/Youth's Residing Address:

Child's Current Living Arrangement (Please check applicable box):	
[ ] (0) Unknown	[ ] (10) Residential Treatment Facility (Other than DCF Operated)
[ ] (1) With either or both parents	[ ] (11) Hospital in the Community, Psychiatric Unit
[ ] (2) With relative other than parent	[ ] (12) Hospital in the Community, Medical Bed
[ ] (3) Foster home (in the community)	[ ] (13) Psychiatric Hospital
[ ] (4) Foster home (out of the community)	[ ] (14) DCF Residential Treatment
[ ] (5) With friend or family friend	[ ] (15) DCF Psychiatric Hospital (Riverview)
[ ] (6) Emergency shelter for children	[ ] (20) Crisis Stabilization Bed
[ ] (7) Family homeless shelter	[ ] (98) Homeless
[ ] (8) Safe Home/Host Home	[ ] (99) Other
[ ] (9) Group Home (Other than DCF Operated)	

School	Grade:	Special Ed: Yes [ ] No [ ]	Section 504: Yes [ ] No [ ]
DCF Social Worker:			Phone:
Parent(s)/Guardian(s) Name:			
Parent(s) Address:			
Phone: (Home)	(Work)	(Cell)	(Other)
Email Address:			
Is the biological parent the legal guardian? Yes [ ] No [ ]		If no, who is?*	

Family Type (Please check applicable box):	
[ ] (5) Emancipated	[ ] (12) Adoptive Family Two Caregivers
[ ] (8) Biological Family Two Caregivers	[ ] (13) Adoptive Family One Caregivers
[ ] (9) Biological Family One Caregivers	[ ] (14) Relative and/or Guardian Care Two Caregivers
[ ] (10) Foster Family Two Caregivers	[ ] (15) Relative and/or Guardian Care One Caregivers
[ ] (11) Foster Family One Caregiver	[ ] (99) None of the above

Primary Language Parent (Please check applicable box):
[ ] (1) English [ ] (2) Spanish [ ] (3) Other European [ ] (4) Asian [ ] (5) African [ ] (98) Other [ ] (99) Unknown

Primary Language Child (Please check applicable box):
[ ] (1) English [ ] (2) Spanish [ ] (3) Other European [ ] (4) Asian [ ] (5) African [ ] (98) Other [ ] (99) Unknown

Please check all that apply:
Child lives with: Mother [ ] Father [ ] Other [ ] (Specify) _____

Other relevant family members/persons in household	Relationship	Age	School	Grade

Other Referral Concerns:

Clinical Diagnoses (if known):

Diagnosed by/Date:

Child previously referred to Systems of Care: [ ] Yes [ ] No If yes, what collaborative or region:

Service Providers – Current and Previous

Dates	Name	Agency	Number

Please note child's functional impairment/strengths in relation to: (Please check all applicable reasons for referral below)		
[ ] (1) Suicidal Ideation	[ ] (22) Witness of Physical Assault	[ ] (43) Sleep Disturbance/Sleep Disorder
[ ] (2) Suicidal Attempts/Gestures	[ ] (23) Victim of Physical Assault	[ ] (44) Severe Sibling Conflict
[ ] (3) Depressed	[ ] (24) Victim of Other Violent Crimes	[ ] (57) Police Contact
[ ] (4) Self-Mutilation	[ ] (25) Pregnancy of the Child	[ ] (58) Property Damage
[ ] (5) Other Self-Injurious Behavior	[ ] (26) High Risk Behavior (Dangerous Play, Promiscuity)	[ ] (59) Theft
[ ] (6) Suicide by Family Member	[ ] (27) Relocation of Family	[ ] (60) Threat to Life of Others
[ ] (7) Death or Loss of Significant Other	[ ] (28) Peer Relationship Problems	[ ] (61) Extreme Verbal Abuse
[ ] (8) School Phobia	[ ] (29) Physical Disability	[ ] (62) Cruelty to Animals
[ ] (9) Suspension from School	[ ] (30) Homicidal Ideation	[ ] (63) Social Contact Avoidance
[ ] (10) Being Expelled from School	[ ] (31) Homicidal Plan	[ ] (64) Over Dependence on Adults
[ ] (11) Running Away	[ ] (32) Physical Violence/Aggression by the Child	[ ] (65) Truancy
[ ] (12) Being Expelled from Home	[ ] (33) Oppositional Behavior	[ ] (66) Academic Problems
[ ] (13) Eating Disorder	[ ] (34) Sexual Offending by the Client	[ ] (68) Somatic Complaints
[ ] (14) Alcohol Abuse	[ ] (35) Sexual Abuse of the Client	[ ] (71) Bladder Difficulties
[ ] (15) Marijuana Abuse	[ ] (36) Fire-setting	[ ] (72) Non-Compliance
[ ] (16) Amphetamine Abuse	[ ] (37) Delinquent Activities	[ ] (73) Strange Behavior
[ ] (17) Other Substance Abuse	[ ] (38) Symptoms of Psychosis (delusions, thought disorder, etc)	[ ] (74) Hyperactive/Impulsive
[ ] (18) Significant Time Living Apart from Parents	[ ] (39) Severe Mental Illness not Specified Above	[ ] (75) Attentional Difficulties
[ ] (19) Severe Parent-Child Conflict	[ ] (40) Anxiety-Related Symptoms	[ ] (76) Poor Self-Esteem
[ ] (20) Witness of Domestic Violence	[ ] (41) Other problem not listed above	[ ] (77) Sexual Acting Out
[ ] (21) Witness of Homicide	[ ] (42) School Refusal	[ ] (93) Problematic Bowel Activity

Area	Strengths	Reasons for Referral (Please enter codes from previous page)	Examples/Description of Behaviors
Home & Family			
School			
Community			

Signature of parent/guardian is *REQUIRED* for processing

"I understand that my signature gives the referring agency permission to share the above information necessary for the referral with the Care Coordinator for the local System of Care Collaborative. I understand that this information will be used to determine eligibility for the Systems of Care."

Signature of Legal Guardian: _____

Date: _____

FAVOR, Inc. (www.favor-ct.org) is a statewide family advocacy organization, run by and for parents/guardians of children with mental health needs in Connecticut. They work collaboratively with local Community Collaboratives/Systems of Care to help families who are referred for Care Coordination. The FAVOR Family Advocacy program provides trained Family Advocates who can assist families through individual advocacy, including help in learning how to effectively advocate for their child in school, juvenile justice services or other family-identified priorities. The advocates assist families in participating at meetings, provide information/help in learning how to access resources, and linkage to parent-to-parent support.

I am not interested in FAVOR services at this time [ ]

I would like to receive additional information on FAVOR, Inc. [ ]

I would like my referral to be forwarded to FAVOR for Family Advocacy Services [ ]

Signature of Legal Guardian: _____

Date: _____

CT System of Care Uniform Client Record: II. ELIGIBILITY REVIEW

NOTE: Eligibility for Level III Care Coordination services is based on criteria in the Practice Standards For Systems of Care and the Care Coordination contract. Determination for eligibility must be based on (a) Severe Emotional Disturbance (confirmed by Axis I diagnosis or "diagnosable" behavioral or emotional problems); (b) need for multi-agency involvement (as reflected on the list providers on the Referral Form; and (c) risk of placement if services are not provided or return placement only if services are provided.

Child/Youth's Name:		
Local Collaborative/System of Care:		Date:
[ ] Child/family informed about the nature of the Systems of Care and services available through it*		
[ ] Grievance procedure discussed with and provided to parent/guardian**		
[ ] Discussion of confidentiality***		
[ ] Discussion of mandated reporting requirements****		
[ ] Discussion of Administration Service Organization (ASO)***** ASO Notified [ ] Yes [ ] No Date ASO Notified:		
Current DCF Status******		
[ ] (97) No known DCF Status	[ ] (4) Committed FWSN	[ ] (8) Voluntary Services
[ ] (1) Dual Commitment	[ ] (5) Protective Services	[ ] (12) No current, but previous DCF involvement
[ ] (2) Committed Abuse/Neglect/Uncared for	[ ] (6) FWSN/Non-Committed	[ ] (19) Non-committed Treatment Program
[ ] (3) Committed Delinquent	[ ] (7) Delinquent/Parole Services	[ ] (28) 136 Filed
Name of current/recent DCF Worker:		

Eligibility Outcome (please check one)

[ ] Case Accepted for Level 3 Care Coordination [ ] Case Not Accepted for Level 3 Care Coordination

Reason for Wait List:

(1) [ ] Waitlist for CC (CC is full)
(2) [ ] Specific service is unavailable (e.g., bilingual staff)
(3) [ ] Ancillary support for family unavailable (e.g., transportation)
(4) [ ] Family is unavailable
(6) [ ] Not Applicable
(7) [ ] Transition pending from other case management service

Assessment Scheduled on:	Check Level to be provided: [ ] 1 [ ] 2
Alternative Care Coordination Offered by:	
Agency:	Phone:

Case referred to outside services: [ ] Yes [ ] No

If yes, please list the referrals made:

*See Operational Definitions – Systems of Care
**See Operation Definitiions – Grievance Procedure
***See Operational Definitions – Right to Confidentiality
****See Operation Definitions – Mandated Reporting
*****See Operational Definitions – ASO
******See Operational Definitions – DCF Status

Operational Definitions

* A System of Care is a comprehensive spectrum of community-based mental health and other related necessary services. These services are coordinated by the Care Coordinator to meet the multiple and changing needs of children/adolescents who are SED and their families. The family will decide the types and mix of services provided. All services are voluntary for a family and they may choose not to accept services. However, if a family has a Treatment Plan with DCF they must still follow the plan, and the System of Care can only enhance services for the family.

**A Grievance Procedure was established by Public Act #92-272. A family may appeal any decision made at any level of the System of Care within 45 days of the decision, including the denial of acceptance into the System of Care. At the time of intake families will be given a copy of their rights per the Practice Standards for Systems of Care. A copy of the Grievance Procedures will also be given to the family. This will include the name and phone number of the person to contact if they wish to appeal a decision.

***Each System of Care shall inform the family of their right to confidential services. Each member of the System of Care will sign an confidentiality statement which states that information discussed at any level will not be shared outside of the meeting without the proper releases of information. Releases of information shall include the following information: what information will be shared, with whom the information be shared, and for what purposed the information is being shared. Families have the right to release only the information they deem necessary to obtain the requested services. Families should only be asked to sign the referral form for the System of Care before acceptance into the System. Other releases of information should be signed subsequently.

****All service providers and Care Coordinators within the System of Care are "Mandated Reporters" under the law of the State of Connecticut General Status S17a-101(b) and must file a report of Suspected child Abuse/Neglect (DCF 136) with the DCF Hotline if they suspect that a child/adolescent may have been abused or neglected.

*****The Administrative Services Organization (ASO) is a state contracted entity that establishes a common administrative infrastructure between The Department of Social Services (DSS) and the Department of Children and Families (DCF). The purpose is to enhance behavioral healthcare by improving access to care, coordination of care, and quality of care. Through the services of one contracted organization (Value Options) that reports directly to DSS and DCF, publicly funded behavioral health benefits from the Medicaid program and from DCF grants and contracts are organized and monitored in a coordinated and integrated fashion.

The ASO will authorize admissions to various levels of care, track the care of individual children and groups of children across services, identify and assist children and families for whom existing services do not appear to be working, help consumers and others identify all available resources, and connect children and families to crisis services. Unlike the existing managed care companies, the ASO will not be at financial risk and the clinical protocols and rates will be determined by both Departments with input from parents, consumers, and providers. These changes will support a more transparent and collaborative system. The ASO's website is www.ctbhp.com.

****** -No known DCF Status
-Dual Commitment; Child has been committed under more than one category
-Committed Delinquent: Child has been adjudicated delinquent and committed to DCF as a delinquent. Placement is at the discretion of DCF, an alternative such as a Group Home or Aftercare Parole Services, if placed other than Connecticut Juvenile Training School, will provide supervision. DCF has custody .
-Committed FWSN: Child has been committed to the care and custody of the Commissioner of DCF after finding the family is a family with service needs.
-Protective Services: Child is not committed to DCF, not in Non-committed Treatment Program, but child/family is receiving Regional Office services (including investigation)
-FWSN/Non-Committed: Adjudicated FWSN without commitment to DCF
-Delinquent/parole services; Adjudicated delinquent without commitment to DCF.
-Voluntary Services: Child/Family has elected to participate in the DCF Voluntary Services program
-No current, but previous DCF involvement
-Non-committed Treatment Program

SAFETY PLAN

Child's Name:	
Local Collaborative/System of Care:	Date:

Important Contacts:	
CARE COORDINATOR:	Phone:
THERAPIST/COUNSELOR:	Phone:
CARE GIVERS:	
	Phone:
	Phone:
	Phone:
	Phone:
FAMILY/COMMUNITY SUPPORTS:	
	Phone:
	Phone:
	Phone:
	Phone:
EMERGENCY MOBILE PSYCHIATRIC SERVICES (EMPS):	Phone:

Current Medications for the Child/Youth		
Name of Medication:	Dosage:	Prescriber/Phone Number
Are there any PRN's:		
Prescribed by:		

List the types of situations that may prompt a crisis (Describe who does what for each situation listed):

SAFETY PLAN

What specific techniques would be effective in resolving crises? What does the child respond to? What should be avoided? Please list examples (list example, steps to be taken, include strengths and resources):
What can help the caregiver in a crisis (resources, another caregiver stepping in, who will take the lead in the situation?)

REMEMBER, YOU ARE THE EXPERT ON YOUR CHILD/YOUTH. IF YOU FEEL YOU NEED EMERGENCY ASSISTANCE AT ANY TIME, DON'T HESITATE TO MAKE THAT CALL. IF YOU ARE UNSURE, SOME SUGGESTED GUIDELINES ARE PROVIDED BELOW:

Call Clinical Provider OR EMPS/EMS if:

- [ ] There are significant changes in child's mood/behavior
- [ ] Child has made suicide statement
- [ ] Child has made threat to cause serious harm to self or others
- [ ] Other (Specify)

Call 911 if there are any concerns regarding immediate safety:

- [ ] Child requires medical attention
- [ ] Child has made suicide gesture/attempt
- [ ] Child has made gesture/attempt to harm others
- [ ] Other (Specify)

Identified Behavior/Concern	Stress reducing strategies/ coping skills

Child's Name:	Date Assessment Began:
Local Collaborative/System of Care:	

Strengths and Needs (As seen by the child and family)	
Strengths	Needs
Child/Family:	
Safety:	
Social/Recreational:	
Psychological:	
Educational/Vocational:	
Legal:	
Living Situation:	
Medical:	
Cultural/Spiritual:	
Other:	

Family Vision
Where would you like to see your family in six months?
If you could wave a magic wand and meet all of your family's needs what would that look like?

Self Care:
Child/Adolescent Substance Use:
History of neglect/abuse/trauma:
Identification of other members of the household needing mental health or substance use services:

Parent's Perception of stress level in the home: (1 = extremely calm and 10= extremely stressful)	

Clinical Diagnosis as reported by most recent contact with a clinician:

AXIS I		
__ __ __ . __ __		Date:
__ __ __ . __ __		Date:
__ __ __ . __ __		Date:

AXIS II		
__ __ __ . __ __		Date:

AXIS III		
__ __ __ . __ __		Date:

AXIS IV		
__ __ __ . __ __		Date:

AXIS V (GAF)		
		Date:

Child's Medications	Dosage:	Prescribed By:

Child's Insurance: [ ] Husky A [ ] Husky B [ ] Private

Insurance Company:	Child's Insurance #:

Number of days absent from school in the past 60 days (last 2 months):	Expelled: Yes [ ] No [ ]	Number of days suspended:

Psychiatric Hospitalizations	
Dates/Number of days in Hospital	Location

Partial Hospitalization Programs	
Dates/Number of days in PHP	Location

Intensive Out-Patient	
Dates/Number of days in IOP	Location

Extended Day Programs	
Dates/Number of days in EDT	Location

Out of Home Placements	
Dates/Number of days in Out of Home Placements:	Location

Outpatient Counseling	
Dates/Number of days in Outpatient Counseling sessions:	Location

Emergency Mobile PsychiatricServices (EMPS)	
Dates/Number of EMPS Occurrences:	Location

Child and Family Needs Assessment:

[ ] In-patient Hospitalization	[ ] Public Assistance	[ ] Early Intervention Services
[ ] Emergency Shelter	[ ] Health Insurance	[ ] Medical Assessment
[ ] Food	[ ] Child Care	[ ] Psychiatric Evaluation (Medical)
[ ] Clothing	[ ] Transportation	[ ] Neurological Evaluation
[ ] Sexual Abuse/Assault Services	[ ] Employment/Training services: [ ] Parent [ ] Child	[ ] Psychological Evaluation
[ ] Domestic Violence Services ("have you ever been hit, kicked, punched, shoved or made to feel threatened or intimidated")	[ ] School Intervention: [ ] PPT/Evaluation [ ] Other	[ ] Voluntary Services (DCF)
[ ] Partial Hospitalization or IOP	[ ] Therapeutic Preschool or Head Start	[ ] DMHAS Application
[ ] Extended Day Treatment	[ ] Legal Assistance with:	[ ] DMR Application
[ ] In-Home Services: [ ] Behavioral [ ] Medical	[ ] Respite-Traditional	[ ] Transitional Services
[ ] Mental Health Counseling (outpatient) [ ] Child [ ] Family	[ ] Mentoring-Traditional	[ ] Youth/Recreational Services
[ ] Substance Abuse Services [ ] Child [ ] Family	[ ] Therapeutic Respite	[ ] Summer Programming
[ ] Other:	[ ] Parent Aide	[ ] Discretionary Funding (where available):
[ ] Other:	[ ] Other:	[ ] Other:

Intelligence Quotient (IQ)-(If available):	IQ Test Used (If known):	Date Administered:

Legal History:

# Of Runaway Incidents:	Dates:
Arrests: [ ] Yes [ ] No	Date of most recent arrest:
Currently on probation: [ ] Yes [ ] No	Name/Phone Number of Probation Officer:
Currently on parole: [ ] Yes [ ] No	Name/Phone Number of Parole Officer:
Name of Defense Attorney:	Name of conservator (if applicable):
Spent time in Detention, Training School or Correctional Facility? [ ] Yes [ ] No	
If yes, what facility and when?	

OHIO Scales				*BERS*	
	Child	Parent	Worker		Standard Score
Problem Severity				I. Interpersonal (IS)	
Functioning				II. Family Involvement (FI)	
Hopefulness				III. Intrapersonal Strength (IaS)	
Satisfaction				IV. School Functioning (SF)	
				V. Affective Strength (AS)	
				BERS Strength Quotient:	

Community Supports Identified

Referrals Made:	Dates:

Key Information for Child Specific Team Meeting:

Releases Signed: [ ] Yes [ ] No

I have reviewed the above document and am in agreement with the information contained within.

Signature of Parent/Guardian:	Date:
Signature of Child/Youth:	Date:
Signature of Care Coordinator:	Date:

Assessment Completed on: _____

CT System of Care Uniform Client Record: V. CARE PLAN INFORMATION SHEET
Note: Care Plan only sent to Team participants

CARE PLAN AGREEMENT

I,/We (Parent/Guardian/Majority Aged Individual) _____authorize the members of the Child Specific Team to share and exchange information about my child/self:

Name _____ Date of Birth _____

To be held on _____ at _____

I understand that it is my right to attend this meeting and that the Practice Standards for the System of Care prohibit this meeting being held without my attendance. I have the right to invite only the persons that I want to attend and I reserve the right to ask anyone to leave at any time during the Child Specific Team.

All information will be held confidential and used only to coordinate/plan supports and services to meet the needs of my child and family and to follow-up on my child's Care Plan. I understand that all Team members present will sign a statement regarding the confidentiality policy at the start of the Team meeting.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Child/Youth Date

It is the obligation of the members of the Child Specific Team to adhere to the principles and terms of confidentiality outlined in this policy.

1. Communication with families/guardians originates with their confidence that any information shared and observed regarding them or their children will not be disclosed to anyone outside of the team without their written permission.

2. Privileged communication must be broken where the information disclosed by a child, family, guardian or individual gives reasonable cause to believe that a child's life or their life is in imminent danger (i.e., medical emergency, suicidal/homicidal risk, or where there is know or suspected abuse/neglect under applicable State of Connecticut General Statutes (Conn. Gen. Stat. S17a-101 (b) for mandated reporting).

As a member of the Child Specific Team, I understand that I may share and exchange pertinent information with only providers authorized on the Release of Information for this meeting, which is signed by the parent(s), legal guardian(s) or majority aged client(s). I understand that the team is parent/guardian driven, therefore, only the information on the signed release may be shared. As a member of the team, I understand that his meeting cannot start or be held if the parent/legal guardian is not in the room.*

I, the undersigned, have read through this policy and my signature indicates that I will adhere to this policy as outlined above:

Child Specific Team Participants			
Print Name	Phone Number	Agency	Position/Role
Signature:			
Print Name	Phone Number	Agency	Position/Role
Signature:			
Print Name	Phone Number	Agency	Position/Role
Signature:			

Note: Care Plan only sent to Team participants

CARE PLAN AGREEMENT

Child SpecificTeam Participants			
Print Name	Phone Number	Agency	Position/Role
Signature:			
Print Name	Phone Number	Agency	Position/Role
Signature:			
Print Name	Phone Number	Agency	Position/Role
Signature:			
Print Name	Phone Number	Agency	Position/Role
Signature:			
Print Name	Phone Number	Agency	Position/Role
Signature:			
Print Name	Phone Number	Agency	Position/Role
Signature:			
Print Name	Phone Number	Agency	Position/Role
Signature:			
Print Name	Phone Number	Agency	Position/Role
Signature:			
Print Name	Phone Number	Agency	Position/Role
Signature:			
Print Name	Phone Number	Agency	Position/Role
Signature:			
Print Name	Phone Number	Agency	Position/Role
Signature:			

CT System of Care Uniform Client Record: V. CARE PLAN

Name of Child:	Date:

Identified Need #	Life Domain (Please choose from codes below)	
	[ ] (F) Family	[ ] (L) Legal
	[ ] (S) Safety	[ ] (LS) Living Situation
	[ ] (SR) Social/Recreational	[ ] (M) Medical
	[ ] (P) Psychological	[ ] (C) Cultural/Spiritual
	[ ] (E) Educational/Vocational	[ ] (O) Other

Need:

Desired Outcome:

Action Steps/Strategies:	Person Responsible:	Timeframe:

Supporting Strengths:

Final Outcome:

Date Need Met:

Comments/Other:

Parent Guardian Initials: _____ Youth Initials: _____

CT System of Care Uniform Client Record: V. CARE PLAN

Name of Child:	Date:

Identified Need #	Life Domain (Please choose from codes below)	
	[ ] (F) Family	[ ] (L) Legal
	[ ] (S) Safety	[ ] (LS) Living Situation
	[ ] (SR) Social/Recreational	[ ] (M) Medical
	[ ] (P) Psychological	[ ] (C) Cultural/Spiritual
	[ ] (E) Educational/Vocational	[ ] (O) Other

Need:
Desired Outcome:

Action Steps/Strategies:	Person Responsible:	Timeframe:

Supporting Strengths:
Final Outcome:
Date Need Met:
Comments/Other:

Parent Guardian Signature: _____ Date: _____

Youth Signature: _____ Date: _____

Care Coordinator Signature: _____ Date: _____

CT System of Care Uniform Client Record: VI. CASE CLOSING FORM

Child's Name:	DOB:
Local Collaborative/System of Care:	Date:

Reason for Discontinuation of Service (Please check applicable box):

[ ] (1) Presenting problem Resolved and child is Stable	[ ] (9) Agency initiated Discontinuation
[ ] (3) Child/Family Moved	[ ] (10) Child is Deceased
[ ] (4) Child's condition required outpatient care and/or community supports	[ ] (11) Services to be provided by another agency/program
[ ] (5) Child's condition required inpatient treatment or residential treatment	[ ] (12) Child removed from home/community by DCF
[ ] (6) Child chose to discontinue before presenting problem was resolved	[ ] (13) Family chose to discontinue before presenting problem was resolved
[ ] (8) Incarcerated	[ ] (99) Other

If other applies, please state the reason:

Diagnoses at Closing

Diagnosis:	Diagnosed By:	Date:

Educational Status:

Grade Level: _____	Special Education: [ ] Yes [ ] No	Section 504: [ ] Yes [ ] No

Number of days absent from school 60 days prior to case closing:

Please identify *ALL* supports and services the child/youth & family were connected with during the time the case was open. If other, please describe:

[ ] (1) Emergency Mobile Psychiatric Services	[ ] (22) DCF Residential Facilities (CCP & HM)	[ ] (42) Recreational Services
[ ] (2) Care Coordination	[ ] (23) Riverview Hospital	[ ] (43) Organized Sport Services
[ ] (3) Family Advocacy	[ ] (24) Substance Abuse Family Evaluation	[ ] (44) Tutoring
[ ] (4) Extended Day Treatment	[ ] (25) Alcohol and Drug Prevention	[ ] (45) Religious Group Services
[ ] (5) Child Evaluation Services	[ ] (26) Substance Abuse Screening	[ ] (46) Volunteer Activity
[ ] (6) Out-Patient Services and Child Guidance Clinics	[ ] (27) Multi-Systemic Therapy	[ ] (47) Parent Aide
[ ] (7) Behavioral Health Consultation Services	[ ] (28) Community Adolescent Out-Patient Substance Abuse	[ ] (48) Vocational Services
[ ] (8) In Home Services	[ ] (29) Adolescent Substance Abuse Evaluation	[ ] (49) Peer Support Services
[ ] (9) Visiting Nurse	[ ] (30) Substance Abuse Family At Risk	[ ] (50) Comprehensive Case Manager
[ ] (10) Intensive Out-Patient Services	[ ] (31) Substance Abuse Support Groups	[ ] (51) Other Case Management
[ ] (12) Therapeutic Foster Care	[ ] (32) Residential Substance Abuse – Short Term	[ ] (52) Other Non-Traditional Services
[ ] (13) Therapeutic Child Care	[ ] (33) Supportive Housing for Recovering Families	[ ] (55) Department of Mental Retardation DMR
[ ] (14) Behavior Management Paraprofessional	[ ] (34) Residential Substance Abuse	[ ] (74) Psychiatric Evaluation
[ ] (15) Medication Management	[ ] (35) Other Advocacy	[ ] (76) Professional Mentoring
[ ] (16) Early Childhood Services	[ ] (36) Informal Support Network for Parent	[ ] (77) Non-Traditional Mentoring
[ ] (18) Crisis Stabilization Beds – Short Term	[ ] (37) Entitlements, Concrete Services	[ ] (78) Professional Translator/Interpreter
[ ] (19) In-Patient Psych Services	[ ] (38) Camp	[ ] (79) Non-Traditional Translator/Interpreter
[ ] (20) Partial Hospitalization	[ ] (40) Family Preservation	[ ] (80) Professional Respite Care for Patients
[ ] (21) Residential Treatment Centers	[ ] (41) Family Reunification	[ ] (81) Non-Traditional Respite Care for Patients

If no code applies, please describe the service(s) below:

Using the Supports and Services list on the previous page, please identify all services that were needed but not available (list code numbers here):

Number of Admissions to Residential Treatment Facilities since case was opened:

Total number of Days in Residential Treatment Centers since case was opened:

Number of Psychiatric Hospitalizations since case was open:

Number of Days Hospitalized:

Number of Partial Hospitalizations/Program Admissions since case was opened:

Number of Days participating in Partial Hospitalization since case was opened:

Number of Outpatient Sessions:

Number of EMPS Interventions:

Number of Admissions to Extended Day Treatment since case was opened:

Number of Days of Extended Day Treatment since case was opened:

Number of Arrests since case was opened:

OHIO Scales

	Child	Parent	Worker
Problem Severity			
Functioning			
Hopefulness			
Satisfaction			

BERS

	Standard Score
I. Interpersonal (IS)	
II. Family Involvement (FI)	
III. Intrapersonal Strength (IaS)	
IV. School Functioning (SF)	
V. Affective Strength (AS)	
BERS Strength Quotient:	

Parent's perception of stress level in the home: (1=extremely calm and 10=extremely stressful)